THE MEDICO-LEGAL SOCIETY

Notes of a meeting

held at

The Medical Society of London
11 Chandos Street, London W1

on

Thursday, 11th May, 2017

The President

Dr Daniel Haines
(in the Chair)

Guest Speaker

Dr Oliver Quick

The Medico-Legal Society

A meeting of the Society was held at the Medical Society of London, 11 Chandos Street, Cavendish Square, London, W1G 9EB, on Thursday, 11th May, 2017. The President, Dr Daniel Haines, was in the Chair.

Medical Manslaughter – Time for a Rethink?

Dr Oliver Quick
Reader in Law, University of Bristol

The President: Good evening, ladies and gentlemen

Dr Oliver Quick is Reader in Law at the University of Bristol Law School and he is going to speak about *Medical Manslaughter – Is it time for a rethink?* He has a long history of interest in the safety of healthcare and, sadly, it is true that dangerous doctors have become recognised as a serious public health issue. It is a little alarming for most of us medics here to accept that we are a public health hazard, but apparently we are. This subject is naturally of interest to doctors but unfortunately it is increasingly interesting for litigious lawyers as a potentially lucrative source of income, and indeed we have some of them among us here tonight. (Laughter) So welcome, Dr Quick. (Applause)

Dr Quick: Well, thank you, President, and good evening everyone. I am absolutely delighted to be here tonight to address you on the subject of medical manslaughter. I have very fond memories, as law student some 20 years ago, discovering the Medico-Legal Journal in the library at Cardiff University and particularly enjoying reading the published talks and the rich discussion that follows all of them. so I am happy to be here to deliver a talk and look forward to seeing it in the pages of the journal. Before I begin can I also thank Dr Martin Mansell, past president of the Society, for inviting me to address you this evening.

Medical manslaughter cases have always been controversial and interesting, and even more so given the recent successful, and somewhat surprising, appeal of Dr David Sellu. I will say a bit about that case in a minute. But I think it is fair to say that all of these cases share one thing in common, that they are sad stories of largely preventable deaths: tragedies for the families, and of course the victims, and also shattering for the clinicians involved.

There are clearly numerous issues involved in these cases that deserve detailed attention and I will address what I see as the main medico-legal issues they raise.. I will also summarise the findings of some empirical research which I have carried out with prosecutors and expert witnesses, who clearly play key roles in deciding whether or not cases are criminal ones and, how they proceed through the Criminal Justice System.

To address the question *'Is it time for a rethink?'* the answer is yes, it is. But what do we mean by a rethink? Well, it is unlikely that that is going to involve a rethink of the law. The law of gross negligence manslaughter has a long and somewhat troubled history, yet whilst it remains uncertain it is unlikely to be abolished any time soon. In fact, I don't think it will be abolished at any time at all. However, that does not mean to say there isn't a need to rethink the roles of the key actors in such cases; police, prosecutors, expert witnesses and judges; and to think carefully about whether all cases are being handled fairly?

To start with a bit of legal history. You will need a working knowledge of medieval legal French to read this document.. As far as we know, this is the first published

conviction of a healthcare professional back in 1329. I am grateful to Mr Ian Barker, senior solicitor from the Medical Defence Union, for sending me this. Apparently there are two translations of the case summary - this one says the practitioner was *'commended'* to God, whilst another said the practitioner was *'condemned'* to God. So two quite different interpretations there!

However, the first cluster of cases occurred in the 19th century when we begin to see judges talking about gross negligence alongside recklessness without being too worried about distinguishing between them.

These are key cases in criminal law on manslaughter by gross negligence and they are probably familiar to everybody. But perhaps we should just remind ourselves very briefly of the facts of these leading cases. Only in two convictions, those of of Dr Percy Bateman and Dr David Sellu, were appeals successful.

Dr Bateman was an obstetrician dealing with a difficult delivery. The baby was in the breech position and in performing a manual version he mistakenly removed part of the patient's uterus and caused other internal damage, resulting in death. He was convicted, although his appeal was allowed largely on the basis that the trial judge had not given the jury sufficient detail about deciding what we mean by gross negligence. In the recent appeal of Dr David Sellu, the Court of Appeal similarly found that the trial judge had failed to direct the jury in sufficient detail about gross negligence. It is not entirely clear what further detail judges could give juries in order for them to decide this ultimate issue, but it is interesting that only these two cases were successfully appealed.

Dr Adomako was a locum anaesthetist who took too long to spot a disconnected oxygen tube during a routine eye operation.

Drs Misra and Srivastava were Senior House Officers who failed to diagnose and treat a serious infection in a patient recovering from a knee operation.

Dr Garg was a Consultant Urologist who was too slow to order a scan on his patient with a kidney infection. There was also evidence that he tampered with the medical notes after the patient had died.

More recently, is the conviction of Dr David Sellu, a Consultant Colorectal Surgeon. The prosecution's case was that he was too slow to order a CT scan and operate on a patient with a suspected perforated bowel.

One preliminary question can be quite quickly dealt with, namely, should the criminal law be involved at all in dealing with medical errors? I'd be interested in your thought sin the discussion, but I would be surprised if even the staunchest sympathiser of the medical profession would call for a blanket ban on criminalisation. Some events will always be beyond the pale and warrant a criminal response. But clearly the tough task (and it remains, I think, as tough today as it was in the days of the case of *Bateman*) is to settle on a morally meaningful and fair framework for culpability. Given that these cases involve a wide range of conduct from the blatantly reckless to the momentary slip, this is far from straightforward.

Here are two good illustrations of the breadth of cases that are captured by this category of criminal fault. First, the case of Dr Gray, who in 1952 was convicted following the death of his patient. He was an anaesthetist who was well known for

sniffing anaesthetic gases, and he did this prior to this operation and failed to take care of the patient. Well, I think everybody would agree that such conduct is blatantly reckless. But this is a world away from the case of Dr Falconer, another anaesthetist, prosecuted in 2006 for a momentary slip. He fatally injected oxygen into the wrong tube going into the vein rather than the abdomen of the baby that was being operated on. He was acquitted. These are clearly conceptually distinct, one a clear violation, the other a momentary slip. Morally, I think they are quite different, but legally speaking both are swept up by the broad, and somewhat brutal brush of gross negligence.

Now, legal philosophers have for a long time debated the appropriateness of negligent liability in criminal law. We know that negligence has a fairly long history in civil law and has an equally long history in criminal law, but precisely what is meant by "gross negligence" and also whether it should be an appropriate basis for criminal liability has been a matter of debate for a long time.

Leading philosophers of criminal law have long wondered about negligence liability. H.L.A. Hart defended negligence liability, or "culpable inadvertence" as he called it. Glanville Williams was more critical regarding it as "an unrewarding exercise in moralism" in focusing in on a particular mental deficiency, for example forgetfulness. However, its retention has been supported by the Law Commission, who have reviewed this area twice in the last decade or so, and concluded that the law of homicide would be deficient without manslaughter by gross negligence. But I think it is fair to say that, from a prosecutorial perspective, one of the merits of this test (and we will have a look at what the test says in a moment) is that it is incredibly

malleable. It is something that can apply to a wide range of different types of cases, usually involving individuals with caring responsibilities.

To my mind, "gross negligence" is too broad, too vague and potentially unfair, and I would prefer the threshold of fault to be raised to recklessness. I think there is some merit inmaking it harder to prosecute cases that are on the cusp: cases where perhaps the evidence isn't that strong.

Just to turn for a moment then to the current test of liability, or the four limbs to this area of law: the duty of care; a breach of that duty, which causes, or significantly contributes, to the death of the victim; and then, crucially, those cases will hinge on whether that breach was so bad that it should be judged criminal.

This is a paraphrasing of the test from the leading case of *Adomako,* the House of Lords decision in 1995, where Lord Mackay**,** giving the only judgment in the case, provided the leading common law definition of gross negligence. Now, he acknowledged in his judgment that this test was circular, that if the jury asked (and juries often do ask) 'How negligent must the defendant have been so as to be criminal?' the correct answer is 'So negligent as to deserve a conviction for manslaughter'. So clearly there is an element of circularity to this test. However, it has survived numerous challenges through these cases. Most defendants, through their barristers, have attacked the basis of liability, arguing that the law is insufficiently clear – in short, it is uncertain and unfair.

In the case of *Misra and Srivastava* Lord Chief Justice Judge defended this uncertainty in the law. Here are two interesting extracts from the judgment, where

he says (and to my mind unconvincingly) that there is no uncertainty in the definition of the law; the law is clear; the only uncertainty is in the decision-making process for those who are interpreting the law; so for the police, for prosecutors and of course ultimately, for cases that proceed to trial, for juries. Well, with respect to the Lord Chief Justice, I'm not sure that makes a great deal of sense. One can see why he wanted to defend this basis of liability, but surely if prosecutors and others (and we know this through empirical research) struggle to interpret this legal test, that must have something to do with the fact that the legal test itself is inherently vague. In short, it is too broad and uncertain.

Cases such as *Misra and Srivastava*, *Adomako* and the recent case of Dr David Sellu have, unsurprisingly, caused lots of concern amongst healthcare professionals and others who are at risk of prosecution for such an offence and have attracted lots of academic interest. Here are three books that have been published within the last decade that I would recommend to you, and of course this research goes beyond cases of manslaughter and looks at other areas where the health system and the criminal justice system can interact.

I should also acknowledge a rather good recent dissertation that I was fortunate to read by Dr Martin Mansell. It is an extremely informative and well written LLM dissertation on the criminal prosecution for medical negligence, which I gather was awarded quite a good mark.

Dr Mansell: It's a secret.

Dr Quick: It's a secret. Well, I won't reveal the mark then. Suffice to say, you are not disappointed with the mark, let's put it like that.

Dr Mansell: No, no.

Dr Quick: Okay. How many cases are there? This is a matter of some debate. Has there been an increase in prosecutions and convictions? Well, unfortunately the available data is not sufficiently reliable to draw any firm conclusions here. The Crown Prosecution Service tell us they don't collect or code these cases as medical cases, they fall within a bigger category of killing through gross negligence, and they can't present figures on cases involving healthcare professionals. Now, clearly that must be possible, but I suppose it would take some work in order to pick out those cases.

The best available evidence we have is from literature reviews, mainly of newspaper reporting and case studies in the medical press. The most widely cited is that by Robin Ferner and Sarah MacDowell, from the University of Birmingham, who found that 85 doctors were charged between 1795 and 2005, with 44 of those between 1975 and 2005

The other notable research that has been done within the last decade is by Daniel Griffiths and Andrew Sanders, then at the University of Manchester. They reviewed 75 CPS case files between 2005 and 2009 and found that only 4 of those cases led to prosecution, making clear that, if there is an increase, it is an increase of police investigations, rather than prosecutions.

One thing we can be clear on is that the conviction rate seems to have increased. I have looked at these cases from around the 1950s to the current day and it seems that the conviction rate fluctuated between 30 and 35%, which is relatively low for this category of crime. However, a review by White published in the BMJ in 2015 found that the conviction rate had risen to 55% between 2006 and 2013.

The other point we can note is that more convictions are ending in custodial sentences. Whereas a suspended sentence was once the norm for a guilty verdict, now it seems as though custodial sentences are not uncommon. This followed changes introduced in the Criminal Justice Act 2003 and applied by the Court of Appeal in the case of *Garg*.

Why do cases become cases? Why do some tragic fatalities end in criminal prosecutions whilst others do not?

Well, these seem to be the key factors which influence '**The road to the dock**', as it were.

- the character of victims (especially age and vulnerability)
- families being active and searching for justice through the criminal justice system
- publicity;
- the role of coroners, particularly with prevention of future death reports (Regulation 28 reports)
- interviews of suspects; so what suspects say in interview
- liaison between the police and the CPS
- instructing experts/getting the right experts
- the role of the so-called elite prosecutors of the Special Crime and Counter Terrorism Division that handle and make the decision whether or not to prosecute

And, as the data suggests, the CPS only prosecute a small number of referrals they receive – around three or four cases a year.

The other factor, which I think is particularly interesting and controversial, involves the character of defendants. It seems to me, having looked at these cases, that they are as much about the character of a defendant, or perhaps perceptions about character, as they are about the actual conduct in question. In particular, the defendant's response to the events appear to feed into the assessment of gross negligence. Given the vagueness of gross negligence perhaps it is unsurprising that attention focuses on factors beyond the actual incident in order to search for evidence suggesting gross negligence.

When I first started looking at these cases in some detail what struck me was the seemingly disproportionate number of prosecutions against non-white practitioners. In a paper I published in 2006, I said that whilst the whilst the statistics are small, it suggests that over 50% of prosecutions

involve non-white practitioners, which is disproportionate compared to the number of non-white practitioners working within the health system. Now, caution is required here, because the data is unreliable, so unfortunately we can't speak too confidently about what is going on here.

In fact, we should note that a study of 75 closed cases conducted by Griffiths and Sanders between 2004 and 2009 showed no cleardisproportionality. Some 56% of the cases they looked at involved white practitioners, 3% black, 21% Asian and 20% unknown. The latter is quite a large category and it is a pity that information about the ethnicity of defendants was not available for those cases.

Now, whilst I think caution is required around this issue, one thing that we do know (and again the numbers are small) is that the data on conviction rates is quite stark.

Between 2012 and 2017, to the best of my knowledge, there have been 7 practitioners from the UK and 9 practitioners from outside of the UK by place of primary medical qualification prosecuted, and the conviction rate of cases proceeding to trial is 0% for those from the UK and 78% for those from outside the UK. Now, again we need a longer time span of cases to measure whether that finding is represented over a longer period of time, but clearly that does raise some suspicion about the possibility (I say no more than that) of prejudice creeping in to the construction of cases. Clearly, further research is needed here.

- Now, of course prejudice (if indeed it does play a role) is not the only explanation for this. Clearly there are lots of other factors which are relevant here such as education and training, language skills,working environment,support and supervision, and luck.

But I think we would be a bit naive to discount the potential role of prejudice in why cases become cases and how they are handled throughout the process.

I thought I would now say a little bit about some research findings from studies I have conducted into how prosecutors and expert witnesses negotiated their roles in these cases.

As I mentioned, medical manslaughter cases are classed as highly complex criminal work that should be dealt with by the Special Crime and Counter Terrorism Division of the CPS. There is no getting away from the fact that they find it difficult to apply the *Adomako* test of gross negligence in this context, and they describe their work as being difficult, dynamic, and prone to delays in gathering evidence. They have to

deal with the police, who begin all investigations and who will almost certainly lack experience of conducting investigations in the medical context.

Here are two quotes which reflect the difficulty of interpreting gross negligence.

So here is a quote from a prosecutor interviewed in 2006, saying, "Well, you know, we agonised over this case. Some said prosecute, some said don't prosecute. It wasn't clear cut and we took a long time. It was a borderline case".

And another which suggests that prosecutors actually apply the higher standard of recklessness: "Whilst the law says it is an objective test; in other words, the test of negligence; in reality we're looking for subjective recklessness. It is really a case where we say it is so blindingly obvious that the person must have realised, and therefore they are subjectively reckless".

I think this is an interesting quote, because if you look back at the early cases of medical manslaughter, and indeed at some of the more recent ones, judges do use the term 'recklessness' in describing gross negligence. So it seems as if, whilst these are not synonyms, whilst recklessness implies a greater degree of moral blame , nevertheless in *Adomako* and in *Misra and Srivastava* the Appeal Court Judges were hinting that it was legitimate to focus on recklessness. In fact, what we will see in a moment, with the judgment in the *Sellu* case, is the Court of Appeal talking about "exceptionally bad gross negligence", which further suggests that the courts are subtly raising the bar of liability to a test of recklessness.

The dominant impression I had after conducting interviews with prosecutors was that whilst they were elite lawyers, highly trained specialists in this area, they would not

prosecute without at least two expert reports testifying to the grossness of the negligence. That is a very interesting finding because, strictly speaking, gross negligence is the ultimate issue for the jury and is a legal term of art. However, prosecutors partly devolved that question to experts, even though there is no legal requirement for them to do so.

That in itself raises an interesting question, which again is covered in the appeal judgment in the *Sellu* case, as to what exactly experts are supposed to do in such cases. Can experts testify that the conduct is gross? The short answer is they shouldn't, because that is not their job, and that is one of the reasons, reading between the lines, the *Sellu* appeal was successful, because the appeal court had reservations about experts using the language of "gross negligence" and therefore treading on the toes of the jury in appearing to answer the ultimate issue.

There are a number of really important issues around experts, with two key issues standing out:

- What is the appropriate role of expert witnesses and what is the nature of expertise required in medical manslaughter cases?

A good example is provided by the convictions of the Junior Orthopaedic Surgeons in Southampton, Drs Misra and Srivastava. . This is a case that involved a failure to diagnose toxic shock syndrome. All the evidence came from toxicologists and microbiologists, and there is a question about whether it is appropriate for laboratory doctors to judge the conduct of clinicians working at the coalface of care?

There are thus key questions around:

- How experts are selected.
- How much authority and freedom they have.
- The relationship between experts, lawyers and judges.
- The issue of jury usurpation.
- And how can experts be regulated or managed within the criminal justice system?

Again here are some quotes from my empirical research which I think are worth reflecting on.

Here is a quote touching on empathy. Are the right experts being consulted to pass judgment in terms of the facts of a particular case?

'I thought they were wrong for a number of different reasons. I mean one hadn't done any proper clinical work . . . he was a pathologist . . . you know when was the last time he actually saw a living patient? Probably not for 20 years. And things have changed quite a lot in 20 years…there were two of us that were actively practising in intensive care that actually knew what it was like to have to come in at 2 in the morning and deal with stuff . . . and the others were not in that situation at all.'

Perhaps it is unsurprising that experts have authority, because clearly the nature of being an expert is to have authority, to be confident, and something that became very clear in conducting interviews with experts is that experts – this quote is fairly

representative of most experts interviewed – felt that they were setting the rules of the game, as it were, that they were offering the correct definition of gross negligence.

'If I say they haven't [acted with gross negligence], then they [the prosecution] don't do anything. If I say that they have fallen seriously below that standard, then they usually charge them. But not always.'

One expert confessed to making up his own definition: 'something that no reasonably competent doctor could have done'. He preferred not to use the term "gross negligence", and wisely so given the judgment in the case of Sellu. He preferred the favoured formulation of the Law Commission document, 'where a person has fallen seriously and significantly below the standard expected of them. ' This seems to be a more neutral, less legalistic version of gross negligence.

I will race through some of these quotes as I have probably got too many for the time we have left. Some of the important questions which need to be discussed are about the appropriate role of experts, whether they are too active in terms of becoming team players, and the relationship between experts, lawyers and the adversarial system. Ultimately, there is the risk that experts potentially lose independence and impartiality whilst being swept up within the adversarial legal system.

I mentioned the risk of jury usurpation, the risk of experts telling juries what to do. Of course, strictly speaking, that is not true; juries are making their own minds up; but certainly there has been a concern for some time that in this area of a risk that particularly charismatic, confident experts might appear to be determining the

ultimate issue and a risk that juries may feel that they are being told "This is grossly negligent, therefore you should convict the defendant".

This was acknowledged in the David Sellu appeal. This is the case I mentioned at the outset of the colorectal surgeon who was convicted in November 2013 after being too slow to order a CT scan and to perform surgery on a patient with a suspected perforated bowel. It should be said that this patient wasn't originally his patient. The patient had a knee operation and during recovery experienced some tummy pain and the orthopaedic surgeon asked Dr Sellu to check on the patient and in short, he took too long to operate on the patient who sadly died. He was convicted and, I think controversially, sent to a high security prison for two years. I think he served 15 months of that sentence.

I think what was interesting, and certainly surprising given the fate of other defendants in this context, is that he was successful at his appeal. The Appeal Court Judge, Sir Brian Leveson, acknowledged this risk of jury usurpation when he said that: "Experts might be able to place negligence on a spectrum....but this assistance needs to be considered by the jury in the context of **all** the circumstances as the **jury** find them to be, rather than as evaluated by the experts".

He then went on to say (and this is particularly interesting) that had the judge directed the jury in terms of treatment being "truly exceptionally bad" Dr Sellu could have had no complaint. In short, that was the misdirection of the trial judge, that he hadn't put it to the jury that gross negligence meant treatment that was truly exceptionally bad.

Now, in fact, if we look at the cases, the terms ‘exceptionally bad’, ‘abysmal’, ‘gross negligence’, ‘recklessness’ are used interchangeably in these cases, so it is not entirely clear whether the judge’s jury direction in Sellu was that different from in other cases. It seems to me slightly odd that somebody’s fate could fall on whether or not the trial judge used a synonym for gross negligence, as seems to be suggested here by Sir Brian Leveson.

The most recent appeal judgment was that involving a paediatric doctor from Leicester, Hadiza Bawa-Garba. In her appeal, again heard by Sir Brian Leveson, he made reference to the need to establish a ‘truly exceptional degree of negligence.’ In fact her appeal was unsuccessful, but nevertheless reference to exceptionally bad or an exceptional degree of negligence seems to move the test closer towards recklessness.

Now, I think one of the chief debating points with cases of gross negligence, and indeed I suppose you could say for any legal intervention, is what impact does it have? We know that there is a punishment aspect to such cases, but is there a deterrent effect? What is the impact of criminal law in this context? Well, I suppose the short answer is that we just don’t really know, but certainly there is a strong body of opinion which says that such cases play a negative role in terms of trying to encourage a culture which is conducive to safer healthcare.

A survey conducted in 2016 and cited in The Guardian claimed that doctors were avoiding risky operations due to the threat of prosecution. 668 doctors completed the survey and 70% admitted practising so-called ‘defensive medicine’. 80% believed that criminal law was impacting negatively on a climate of openness and

transparency. Now, I think that is clearly worrying, although it should be said that survey research is clearly not the same thing as actual practice research. People may say one thing to a survey researcher and do another thing in their daily practice. So I think perhaps some caution is required around this notion of defensive medicine, whether it is definitely happening or, as one recent literature review by van Dijck has suggested, that it is all in the mind rather than operating in reality.

For what it is worth, I think that medical manslaughter cases are so few and far between and so damaging to everybody involved that it is highly unlikely that they are positive from a patient safety perspective. I think probably that is the wrong question to ask about these cases, but whether they have got any kind of value in terms of improving levels of safety I think is improbable. That is not to say that other areas of criminal law, particularly regulations enforced by the Care Quality Commission, for example, may not have a more profound effect on delivering safer healthcare, but sporadic prosecutions of errant practitioners is, I would say, unlikely to lead to any positive effect around patient safety.

Okay, so what should be done about all of this? The title of the lecture was "Time for a Rethink?" So what do I think? Well, as I said at the start, to my mind 'gross negligence' is too vague and, despite valiant attempts by Appeal Court Judges to defend and protect 'gross negligence', it is uncertain, unfair and whilst caution is required regarding the data, it is potentially the case that that unfairness is felt more by some than by others.

I would raise the bar of fault to recklessness. This wouldn't solve all the problems in this area but, given that that is a slightly stiffer test of liability, would

perhaps lead to weaker cases not becoming cases in the first place.

I think there is also a good argument for detailed prosecutorial guidance for this offence. Some of you may remember a few years ago the CPS, after a legal challenge, had to publish detailed guidance on factors for and against whether to prosecute individuals for assisted suicide. Well, one could argue that, on the same basis, why not have similar guidance in this context.

I think, connected to that, there is an argument here for greater use of professional codes of conduct, safety protocols/guidelines around the treatment of patients in particular situations to try and, as it were, compensate for the vague form of *mens rea* here. Perhaps professional codes of conduct and evidence based practice can provide some detail in order to assess this rather vague legal test.

But beyond the law, the biggest problem which needs attention is around the regulation of experts and expert evidence. I think that is acknowledged to be a big problem, not only in this area, and given the stakes in such cases and the consequences for those involved, the appropriate management of experts required careful consideration.

I return to the question about the nature of expertise required in these cases, and if you think about the questions that experts are asked to comment on in medical manslaughter cases they are essentially two. One is how bad is the conduct? Do you think it is grossly negligent? And secondly, did it cause the death, or did it significantly contribute towards the death? Well, the second question clearly is one where medical forensic expertise is critical to answer that question. That is a matter of scientific evidence and we clearly need experts to help courts answer that question. But the gross negligence question is arguably much less about science or medicine and more about morality, more about gut feeling and a sense of fairness. This is

where difficulties arise in such cases with the risk that an unduly wide range of factors may creep into the assessment of the grossness of the negligence.

One of the areas that certainly needs attention is the relationship between judges and experts. If we think about the case of David Sellu for a moment, the Court of Appeal Judge Brian Leveson was critical of a misdirection by the trial judge but also critical of one of the prosecution experts for using the language of 'gross negligence. ' Whilst that wasn't strictly speaking the reason for allowing the appeal, nevertheless he expressed reservations about experts using the language of liability, the ultimate issue, and so it raises the question how was the expert allowed to talk in those terms? He allegedly used the term six times during the trial. If that was wrong, how was the expert allowed to do that at trial? So there are real questions there around how judges manage or set the boundaries for what is appropriate evidence to give and then regulate that through criminal trials.

I will finish in a moment, but just to say that the two most recent cases to come before the appeal courts involving Dr Rudling, where there was no case to answer, and Dr Bawa-Garba, whom I mentioned and whose appeal failed, suggest to me that, in terms of rethinking this area, we are, perhaps understandably, reliant on judges to further refine what we mean by 'gross negligence', and it seems as if, on looking at those judgments, there is a consensus that the term 'exceptionally bad negligence' seems to be preferable to 'gross negligence'. Now, I don't know about you, but I am not sure that if I was on a jury I would find that particularly helpful as it is merely a synonym for grossness. So I don't think that the definitional problem in this area goes away, but nevertheless it seems to be an area where it is going to be for judges to rethink and manage, rather than for Parliament.

Okay, I will stop there and invite some questions from the floor and I look forward to discussion.

Discussion

The President: Thank you very much indeed, Oliver. That was a fascinating introduction to the problem, even if you haven't solved it. If you have any questions, please give your name and your field of interest?

Dr Palmer: Hello. Roy Palmer, recently retired Coroner, but before that I worked for the Medical Protection Society and had the privilege of taking the *Adomako* case up to the House of Lords. In view of what you have just been saying, (I think I wholeheartedly agree with you), what are the prospects of the House of Lords revisiting the test and saying "Actually, we got it wrong. It shouldn't have been 'gross negligence', it should have been 'recklessness'", because that was the issue really that was at the core of *Adomako*? If I recall correctly, there were about three simultaneous appeals that went up; *Adomako* was only one; and the issue was that in some cases the trial judges had given directions on the basis of gross negligence and in another they had given a direction on the basis of recklessness, and the view was that it was unfair that 'A' had been found guilty on one test and not the other. They had the opportunity, but, as you say, there was only one speech from Lord Mackay; it was a fairly short one and it was entirely circular. What are the prospects of the House of Lords going back and saying "Actually, we got it wrong; it should be 'recklessness'"?

Dr Quick: I agree, and I think we do need a case of medical manslaughter to reach the Supreme Court, as it now is. The best opportunity for that would have been the case of *Misra and Srivastava*. They challenged the conviction on the same

grounds that Dr Adomako challenged his conviction, that gross negligence breaches the rule of law requirement; it is unclear, it is uncertain; and I think, looking at the judgment there, that argument was given short shrift, it wasn't given the attention it deserved. So I totally agree with you that we do need a case to go to the Supreme Court for a judicial rethink about the correct test for liability and how best to explain this to juries. I think, though, if we do get that case, I kind of worry for the judges – well, I don't worry too much for them - but looking at these cases right through history, the terms 'gross negligence' and 'recklessness', which are clearly quite closely connected, are used in almost all the cases. But as the language of law evolves, there may be an argument for adopting the suggestion of the Law Commission, which was in one of the experts referenced in one of the quotes I put up, and indeed what now features in the Corporate Manslaughter and Corporate Homicide Act, 'a standard falling far below what we would expect of the individual in the circumstances'. What are the prospects of that? Well, I am not sure that the prospects are that good really. It has been a long time since *Adomako* and we only have three or four of these cases a year and only half of them result in convictions, so I wouldn't be too confident that we will have a case reaching the Supreme Court, but I agree with you that that would truly help give us some clarity.

Dr Afif: I am Michele Afif, previously paediatrician, now with the Medical Protection Society. I am particularly interested in the *Bawa-Garba* case. There was such a lot in that case that really related to systems rather than to individuals and so little gets actually said in practice about the accountability of others who perhaps are not medical. What are your thoughts on that?

Dr Quick: Yes, I think that is probably true. It is not every case as there are some cases where it is purely an individual's error, but I think you are absolutely

right that in the vast majority of these cases that error is within a broader system and that certain people have been unlucky and that other individuals may have a case to answer. The *Sellu* case is perhaps a good example of this, in that the private hospital where that care took place did do a root cause analysis which raised some questions about their provision of cover in an emergency situation, which I don't think they were too forthcoming in presenting that evidence at his trial. Now, if I can flip back for a moment to the words of Lord Mackay in *Adomako*, he talks about 'reference to all the circumstances'. So strictly speaking, the legal test does require the assessment of fault with reference to all the circumstances. But whether all the circumstances are given due weight in the trial relies on that evidence becoming apparent and on that evidence being interpreted appropriately. Again, the *Sellu* case is quite revealing here. In the sentencing remarks the judge found it was an aggravating feature that this care took place in a private hospital. He said words to the effect of "Well, this didn't take place in an under-funded, overstretched NHS hospital, this took place in a private hospital. This is even worse". In actual fact, as medics in the room will know, and perhaps the lawyers in the room will know, the opposite was true, that the patient would have been safer in an NHS hospital, where there would have been on call anaesthetic cover and the procedure may well have taken place sooner and the patient may well have survived. So I wholeheartedly agree with your point. I think it is a critical point in these cases that the context requires careful understanding of the factors that explain why patient safety incidents occur in the first place. I think what would be helpful as the research base for improvement science or patient safety research increases, is that we get a better understanding of how things happen in the first place, a better understanding of the role of systems in trying to prevent tragedies.

Mr Coonan: I thoroughly enjoyed your talk. May I say that I don't agree with a lot of it. Perhaps I should introduce myself. I am Kieran Coonan, Queen's Counsel, and I defended in three, if not four, of the cases that you have cited, including David Sellu. Can I just ask you, first of all, about the premise of this address? Do you agree that there is no offence of medical manslaughter?

Dr Quick: Yes, the offence is manslaughter by gross negligence. Medical manslaughter is just a type of case.

Mr Coonan: But of course that offence, albeit an entirely different crime for medics, applies equally to gas fitters, electricians, farmers.....

Dr Quick: School teachers.

Mr Coonan: ....school teachers, everybody, and whilst I can see that there may be disquiet in some respects, that disquiet would have to apply to that category, would it not, of individuals, not just doctors?

Dr Quick: Absolutely, and I wasn't for one minute suggesting that the medical profession or healthcare professionals should have some special exemption here. It just happens to be the area that I am talking about tonight, but I think the law in this area, because it is vague, can also be unfair on other professionals. It is not only professionals but it is mainly professionals who are caring for those who are vulnerable, but I think the same arguments apply whether or not it applies to a medic or a school teacher or carer.

Mr Coonan: I entirely agree. Can I just ask you about the question of systems, which the last speaker raised?

Dr Quick: Yes.

Mr Coonan: Certainly in my experience, which goes back 35 years, the issue of systems is catered for, and catered for well, in the trial process. In some

cases the issue of systems is not deployed. Why? Because the defence don't think it is profitable. That is the first point. Secondly, the issue of systems is deployed, again in my experience, in determining whether there was an error in the first place; in other words, a straightforward *Bolam* error; or whether it was (to use the compendious term) 'gross negligence' or not. It also is deployed in causation, and it is finally deployed when it comes to sentence. *Sellu* wasn't a case involved with that; other ones were. So I am just wondering what your view is: are you saying that systemic factors are not taken into account, by your reading of these cases?

Dr Quick: No, I don't think I said that in the talk.

Mr Coonan: All right.

Dr Quick: I certainly don't say that it is not taken into account. You have obviously got massively more experience of these cases in the courtroom and I agree with you, based on the research I did with prosecutors, that they very deliberately look at context and they carefully consider the negligence in the context in which it occurs. But I am less sure (you may be able to enlighten us) that this always gets the due attention at trial.

Mr Coonan: Well, I was spurred to make the observation because last year, I think in the middle of September, or thereabouts, there was a letter written to *The Times*, signed by about 150 doctors and others, following the conviction of the optometrist in Ipswich. Now, the point there was precisely that, that systems were not taken account of, and I just wanted to express the view, so far as that is a widely held view, that that is simply untenable.

Dr Quick: **The** *Sellu* case is one case, isn't it? If context is taken into account as carefully as you suggest, why was it that the trial judge, who heard all the evidence in the case, felt that the context was aggravating rather than mitigating? To

my mind, that raises some doubt about whether context was understood properly in that case. I admit that is just one case, but it does at least suggest that context may not be fully understood in every case.

The President: I am very sorry, time is against us.

Mr Coonan: Oh, right, fair enough.

The President: Could I give the last question to Martin Mansell? Then we can carry on as long as we like over a glass of wine and some canapés.

Dr Mansell: Obviously I enjoyed the talk. I will be quick. I was involved in one of the CPS prosecutions, the *Garg* case. I was entirely happy that this was whatever I understood by gross negligence manslaughter. There were at least five other experts and I think there may have been one or two I never quite made contact with, and I would just make the observation that if you put five or six little boys together they are all going to start going in the same direction, but, that said, I was happy with the *Garg* case. My question actually is for yourself. Why did the judge allow the misdirections of the jury in *Sellu* that led to the successful appeal? Was he trying to leave the door open to an appeal? Is this conceivable, or are judges not that imaginative? Oliver, what do you think?

Dr Quick: I wouldn't have thought they would be that crafty, personally. I would have to look at this and get access to all of the jury directions, but I wonder (and maybe Mr Coonan can answer this, I don't know) how different the judge's directions in the *Sellu* case (Mr Justice Nicol, I believe) were from other cases. Were they really that different from previous cases?.

Mr Coonan: I entirely agree with you. There is a strong body of legal opinion around who were very surprised by the favourable decision in *Sellu*. I must leave myself out of this, obviously, because I was involved in the trial itself and I am

also privy to material which I am not allowed to reveal because of privilege. However, the direction (you are quite right) mirrored that in *Adomako*; it mirrored that in *Misra and Srivastava*, where I defended, and was therefore no different, but what the judge did do in *Sellu* was to lay it on, and there were other (I can give them to you) extracts from a number of recent cases, *Rudling* being one of them, where the court there also laid it on more to effectively hit the jury between the eyes so that they knew full well what they were determining. So that is the high point. There is no point of principle in tow at all, in my view. It simply restated the law, but gave emphasis to the central proposition, and on that basis the Court of Appeal took a liberal view.....

The President: Let us thank Dr Quick for a most interesting evening and talk. (Applause)
